Date _____

Patient Name_____DOB_____SSN_____

Address_____

City _____State _____Zip_____

Home # (___) _____Cell /Other (___) _____E-Mail_____

(Your e-mail will only be used for TheraMAX communication)

We would like to **FRIEND** you on **FACEBOOK WWW.FACEBOOK.COM/**_____

(This will only be used for communication purposes)

HOW DID YOU FIND US? *(Please provide us with your answer)*

☐Web search | ☐Insurance Co.| ☐YP | ☐Previous patient | ☐Other _____

☐Referred by a TheraMAX patient ***(who?)*** _____ ☐Referred **specifically** by your MD to *Thera*MAX

IS YOUR INJURY THE RESULT OF A CAR AND/OR WORK RELATED ACCIDENT? ☐ YES ☐NO

(IF YES, PLEASE PROVIDE US WITH YOUR CLAIM INFORMATION BELOW)

REFERRING PHYSICIAN

Physician Name_____ NPI#_____

Street Address_____ Ste/Fl._____Telephone_____

City_____ State_____ Zip_____ FAX_____

PRIMARY INSURANCE

Insurance Carrier_____ID#_____

Insurance Co. Phone#_____Group#_____

Policy Holders Name _____Policy Holders DOB_____

SECONDARY INSURANCE

Insurance Carrier_____ID#_____

Insurance Co. Phone#_____Group#_____

Policy Holders Name _____Policy Holders DOB_____

NO-FAULT

Insurance Carrier _____Claim# _____ Date of Accident_____

Contact_____ Telephone_____ Ext. _____ FAX_____

Policy Holder_____Policy#_____

WORKERS COMPENSATION

Insurance Carrier _____Claim# _____ Date of Accident_____

Contact_____ Telephone_____ Ext. _____ FAX_____

Employer_____ Employer's Telephone_____

Address_____

NO-FAULT/WORKERS COMPENSATION ONLY

Attorney Name_____ Telephone_____ Ext._____

I authorize the release of any medical information to my Insurance Carrier to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize the physician(s) to apply for benefits on my behalf for services rendered. I request that payment be made directly to ***Thera*MAX Rehabilitation & Sports Physical Therapy, PLLC**, or its designee. I certify that the information I have reported with regard to my insurance coverage is correct and accurate. I understand that I am financially responsible for the charges incurred for services and supplies received. I authorize the physician(s) to treat me and/or my child.

SIGNATURE _____ **DATE** _____

(Parent/Guardian signature required if patient is a minor)